Accord Housing Association Limited

Silver Birches

Inspection report

23 Tyne Close
Chelmsley Wood
Birmingham
West Midlands
B37 6QZ

Tel: 01217883758
Website: www.accordha.org.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 4 January 2016 and was unannounced .

Silver Birches provides residential care for up to 50 people, some of whom have dementia or physical disabilities. The bedrooms are located on the ground and the first floor. The service is split into three units: Robin, Jay and Kingfisher. Kingfisher unit supports people with advanced dementia who have a high level of care needs. At the time of our inspection there were 49 people using the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us their care and support needs were met by staff who were knowledgeable and knew them well. Staff had undertaken training relevant to the specific needs of people who lived at the home and staff told us they were supported within their job roles.

Everyone we spoke with said they thought Silver Birches was a safe place to live and that they were well cared for. Staff had a good understanding of how to report any concerns of a safeguarding nature. Overall, staff had a good understanding of how to keep people safe. However, we found one occasion when poor communication between the staff team had resulted in the risk associated with a person's care not being well managed.

Staff were not always available at the times people needed them. The registered manager told us actions were being taken to address this. A dependency tool was used to assess the number of staff needed. The number of care staff on each shift had recently been increased during busy periods there were not always enough staff to respond to people's needs without delay. The registered manager told us further actions were being taken to address this.

People received their medicines as prescribed and checks were undertaken to ensure they received them in a safe way.

Mental capacity assessments were completed when needed and specified the nature of the decision the person was being asked to make. This demonstrated that the provider was following the principles of the Mental Capacity Act (2005). When people had a DoLS authorisation in place for continuous monitoring, it was reviewed within the specified time frame to ensure that people were not being deprived of their liberty unlawfully.

Most staff ensured they maintained people's privacy and dignity and treated people with compassion and respect. However, we observed two occasions where this was not the case.

Health and safety risk assessments had been completed. Specific risk assessments had been completed for moving and handling and falls whilst other risks and interventions were assessed using the care plan documentation. Any incidents were logged and an analysis of accidents and incidents was completed so staff could identify any trends and manage them accordingly.

There were robust recruitment procedures in place which included checking people's full employment history, references and a DBS check. This reduced the risk of unsuitable staff being employed by the service.

People's nutritional and hydration needs were being met. People had a choice of meals which met their dietary requirements and preferences. People were supported to maintain their health.

People had opportunities to pursue their hobbies and interests and maintain relationships with people important to them.

People and their relatives knew how to raise complaints and were confident actions would be taken in response to these. People had opportunities to put forward their suggestions about the service provided.

There were processes to monitor the quality and safety of the service provided and actions were taken to drive improvement in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not always safe.

Staff were aware of how to identify risks to people and mostly knew what actions to take to reduce these risks. People who lived at the home told us that they felt safe but staff and relatives did not always feel that there were enough staff available . Medications were stored and administered safely.

Is the service effective?

Good

This service was effective.

Staff received training to ensure they had the relevant skills and knowledge to support people who lived at the home.
Staff had a good understanding of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.
Consent was always sought from people before providing care.
People were supported to eat a nutritional diet based on their needs and preferences.

Is the service caring?

Good

This service was caring.

Staff did communicated to people in a caring manner. People received care that was appropriate for their needs. People were involved in the planning and delivery of their care.

Is the service responsive?

Good

The service was responsive.

People were involved in planning how their care and support was provided. Staff knew people's individual preferences and these were taken account of.
Activities were offered which were tailored to people's interests.
The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

The service was well-led.

People who lived in the home, relatives and other healthcare professionals were asked to provide their feedback of the service. Staff felt supported by the management team. The registered manager had quality assurance and auditing regimes, which had improved aspects of the service through identifying and addressing
areas of concern.

Silver Birches

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 4 January 2016 and was unannounced. The inspection was undertaken by three inspectors and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with 11 people who lived in the home and spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four relatives to gain their views about the quality of care provided.

We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The information provided by the provider reflected what we found during our inspection.

We spoke with the registered manager, a nurse, 10 care workers, a senior care worker and the cook. We reviewed nine people's care records to see how their support was planned and delivered.

We reviewed three staff files and training records for all staff. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Requires Improvement

Is the service safe?

Our findings

A person who lived at the home told us, "I feel very safe here." People presented as relaxed and there was a calm atmosphere in the home. People asked for help from staff when they needed support, this showed that people felt safe within the home.

Staff had a good understanding of how to keep people safe and told us they felt confident in being able to recognise and respond to signs of abuse. They told us, "We have safeguarding training we know what abuse is," and, "I think people are safe, we know to report to management if we have any concerns. If managers don't listen I can phone social services myself." We saw that the phone number for the local safeguarding authority was displayed on a notice board in a communal area. This meant that if anyone had any concerns they could raise them with the relevant authorities.

The registered manager understood and followed safeguarding procedures. Through notifications submitted to CQC we were aware how the registered manager had raised and responded to safeguarding concerns in the past 12 months. For each of these the registered manager had made referrals to external services to reduce the risk of future occurrences. This included referrals to falls assessors, tissue viability nurses and physiotherapists.

Staff told us that they were aware of the provider's whistle blowing policy and a staff member told us they would "Speak out if I needed to." A whistle blower is a person who discloses any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Risk assessments were in place for people who lived in the home and were updated monthly to reflect a person's changing needs. A risk assessment is an assessment that identifies any risks to a person's health, safety, wellbeing and ability to manage daily tasks.

Staff were aware of people's individual risks associated with their care and support and were able to describe how these were managed. For example, one person was at a risk of falls and to reduce the person had been assessed by occupational therapists who recommended that they use a 'moulded' armchair. A member of staff told us, "[Name] has the chair as they tend to slide down in a standard armchair. By having the moulded chair the risk of [Name] falling is reduced."

However, we found that identified risks were not always being consistently managed. One person had developed a pressure sore and on 29 December 2015 a health professional had instructed that a pressure relieving mattress was to be put in place. Records confirmed that this equipment was delivered on 30 December 2015 after the health professional had requested it, but at the time of our visit on 4 January 2016 the equipment was not in use because of a miscommunication between staff and the health professional team. Records from a health professional who visited the person on the day of our inspection stated "Pressure damage deteriorated."

The registered manager was informed of our concerns and by the end of the inspection, the pressure

relieving mattress was in use. The registered manager assured us that actions had been put in place to prevent a similar event occurring again due to poor communication.

We observed that people were able to move around the home and that corridors and rooms were kept free of clutter to reduce the risks of falls. People who had been identified as requiring walking aids had access to these at all times. We examined three walking frames, the plastic guards on the legs of one were very worn and the metal was exposed. This could contribute to a risk of falls for people who lived at the home, especially when walking across different floor coverings. One member of staff told us, "They [walking aids] are not being checked. The handyman used to check them but he left." We raised this concern with the registered manager who told us that care workers were meant to be checking the walking aids during their shifts and she would raise this with them and reiterate the importance of this being done .

A relative told us they had requested a walking aid for a family member who lived at the home. We looked at the falls risk assessment for this person. A falls screening tool had been completed in December 2015 and the staff had completed an action plan which outlined measures in place to reduce the risks of falls. The action plan included making a referral for assessment by the 'falls assessment service' and we saw this had been done. The action plan also identified that staff were to remind the person not to rush when walking around the home. We overheard a member of staff offering this person assistance as they walked across a room. When the person refused help, the staff member reminded the person, "Don't go too fast, we don't want you to fall." This showed that staff were aware of the measures in place and were offering support in line with this.

We checked whether medicines were managed safely. A person told us, "I always have my tablets when I need them; staff are very good like that." We saw that medicines were stored safely and procedures were in place to ensure people received medicines as prescribed. There were regular medicine audits undertaken to ensure staff administered medicines correctly and at the right time. The provider had protocols for medicines prescribed 'as and when required', for example pain relief or medicines for people who sometimes had difficulty sleeping. These protocols gave staff clear guidance on what the medicine was prescribed for and when it should be given. Staff who administered medicines received training and had their competencies in this area regularly assessed by the registered manager.

Staff were not always available at the times people needed them. A person who lived at the home told us, "They need more staff because areas are left unattended when the only one available is needed elsewhere, it becomes an impossibility. "We observed a call bell was not answered for over three minutes and when we went to this person's bedroom we found they were sat on the edge of their bed waiting for assistance to go to the toilet. We intervened and asked a member of staff to assist the person because there was a risk that they would fall if they attempted to walk to the toilet without support. The member of staff stated that they were unable to help because they "could not leave the lounge." A second care worker who had been in another person's bedroom then went to assist the person .

We spoke to staff members who told us "At times it can be difficult if there is not enough staff," and "We have three carers sometimes there is just two. We need help with staff." Another member of staff told us "Sometimes we are short staffed at the weekends. We use agency staff but most have worked here before." They went on to say that more could be done and that staffing levels were their main concern.

The registered manager told us the provider used a dependency tool to calculate staffing levels based on the needs of people who live there. Due to an increase in people's needs, they had increased the number of care staff working each shift from seven to nine. This was in addition to service co-ordinators, domestic staff, kitchen staff and an activity co-ordinator. We were also told that 2 volunteers had been employed to assist

with additional support which did not include personal care or moving and handling.

Agency staff were used to cover shifts where the provider's staff were not able to. Staff told us the registered manager tried to ensure the agency staff were familiar with the home, to ensure consistency for people who lived there. A staff member told us "We have regular agency workers; this is good for the residents because the residents know them." Although staffing levels were kept at a level in accordance with the dependency tool used we observed that due to the often high level needs of people who lived in the home staff were not always able to respond to people's needs in a timely manner which could place people at risk.

The registered manager told us that they were recruiting for new staff in order to reduce the number of agency workers used. A member of staff spoke about their recruitment process which included an interview, references from previous employers and a DBS (Data Barring Service) check. The checks were completed to ensure people who were employed were of good character. This was in line with the provider's recruitment policy.

Good

Is the service effective?

Our findings

We asked a person who lived at the home if staff offered them the support that they needed and we were told "All the staff are great!" and a relative told us, "Staff work really well with my Mum."

Staff received relevant training which gave them the skills and knowledge to effectively support people they supported. Staff told us that the training was useful and that it helped them deliver better care to the people who lived at the home. One member of staff told us they had attended diabetes training and this had given them skills to monitor the diet of a person who had diabetes. The member of staff told us that this training had been provided after the person was diagnosed with diabetes and it was to ensure staff had the knowledge to offer the care and support needed, in order to maintain the person's health. When we looked at this person's care file we saw that their blood sugar was regularly monitored and that for the past 12 weeks their blood sugar levels had been within the recommended range.

When new staff were employed by the service they had an induction period in which time they completed training and were provided information in a staff handbook. Staff told us that during their induction they would shadow other member of staff and that this allowed them to understand how to support people in the home. The induction provided was in line with the care certificate. The Care Certificate is the new minimum standards that should be covered as part of an induction for new care workers.

We observed staff used correct manual handling techniques when assisting people to move from chairs to wheelchairs. Staff told us that they had completed manual handling training and that they were observed by a supervisor at regular frequencies to ensure their training was up to date. Staff received training to support people who lived with dementia. One member of staff told us how after receiving the training they understood how dementia can affect people differently on different days and that one person they supported can sometimes become upset when they try different things. They told us how they had put this training into practice and said "[Person] can become anxious if I try and get them dressed; I will leave them and try again later."

Staff told us that they had regular one to one meetings with their manager. They told us this gave them the opportunity to discuss their training and development needs. One member of staff told us that they had completed their NVQ level three for health and social care. This is a nationally recognised qualification that assesses competence and application of knowledge in regards to health and social care. The member of staff went on to say "I couldn't have done it without my manager's support and belief in me."

A person who lived at the home told us, "The food is very good; I have enough to eat and drink." Food was provided that met people's dietary needs. We saw information displayed in the kitchen about people's allergies, medical conditions which required special diets and preferences. Some people who had difficulties swallowing or were at high risk of choking had soft or pureed diets. The cook explained, "These [pureed meals] are prepared by the kitchen and each food is blended separately to make it look more appealing." The cook told us they tailored recipes such as, "The cakes with less icing are for the few people

who have diabetes, and this means that people with special dietary requirements can still have the same options as other people."

People were offered a choice of meals. People were made aware of the different choices as written menus were available and staff showed people photographs of the different meals. People with dementia may not always understand choices offered to them in a written form, by using photographs of the meals helped people to understand the information given to them and to make an informed decision about what they would like to eat.
The cook told us, "We always have options if people want a lighter meal like scrambled eggs or soup." This showed that the home took peoples preferences into account when planning menus.

Staff had a good knowledge of people's preferred meals and explained that one person "Prefers to eat off a small plate, if they are given food off a larger plate they usually won't eat." We observed at meal times this person was offered their food on a smaller plate.
At lunch time a member of staff sat at a table with three people who lived at the home. The member of staff encouraged people to eat their lunch and supported them when appropriate by helping them hold their cutlery. The member of staff encouraged conversation between all people at the table; this helped the meal time to be a social activity.

During lunch one person repeatedly got up from the table without having finished their meal. A care worker encouraged them back to eat their meal on a number of occasions "I have made you some lovely lunch, come and sit with me and let eat" This encouragement meant that the person ate their meal.

Fluid charts were completed for people who were at risk of dehydration. A staff member told us, "[Name] is prone to urinary tract infections so it is really important that we know how much they have had to drink and we know when to encourage them to have more fluids which reduces the risk of a urinary tract infection." This showed that staff understood why fluid charts were in use and the importance of them being completed accurately. The care records showed that these charts were being completed throughout the day and it had been recorded in handover meetings between shifts if the person needed to be encouraged to drink more.

We saw that people were weighed monthly to help identify any changes in weight. For all the charts we looked at people were at a stable healthy weight but we saw in historical records that appropriate action had been taken following any weight loss or gain which included referrals to their GP or a dietician. A staff member told us, "If people eat less than 50% of two main meals we tell the senior. The senior decides if we need to provide them with more snacks."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that some of the people who lived at the home did not have capacity to make their own decisions. This meant that they needed support to make decisions. Within these people's

care files we saw that their mental capacity had been assessed as required by the Mental Capacity Act 2005. These clearly stated what the person was able to make decisions about and for what they were not able to do. Where a person lacked capacity, best interest decisions were recorded which included discussions with family members and professionals who knew the person. This ensured that any decisions made would reflect the wishes of the individual if they had capacity to make the decision.

We checked whether the service was working within the principles of the MCA. When we asked staff about their understanding of the MCA they demonstrated a good understanding of the principles of the Act. A staff member told us, "We have to assume that people have capacity unless they give us reason to think they don't. If that happens we then have to assess their capacity to do that task. Just because someone doesn't have capacity to go for a walk outside alone doesn't mean that they don't have capacity to choose their meals or know what care they want help with." We observed that staff asked people for their consent before moving them from wheelchairs to lounge chairs and they would wait for permission to be indicated either verbally of through a gesture including nodding the head.

Staff told us that they always offered people choices and although they encouraged people to make a decision that was in their best interests they respect people's ability to choose differently. We observed that one person had dirty finger nails but did not want them to be cleaned. A care worker bought a bowl of warm soapy water and put it in front of the person and encouraged them to put their hands into the water. The person did but after a couple of minutes pushed the bowl away.
The care worker agreed with the person "That's enough for today", and moved the bowl away. This demonstrated how staff respect the decisions of people who live at the home and offer care in a way that supported this. After this activity the person's nails were cleaner and it showed that staff were aware of the importance of good hygiene for people who lived at the home.

Where DoLs authorisations were in place, these included best interest decisions. We saw input in one DoLS authorisation from an Independent Mental Capacity Advocate (IMCA). An IMCA is a legal representative for a person who lacks the capacity to make specific important decisions mainly where there is no one independent of services, such as a family member or friend, who is able to represent the person. In other DoLs authorisations, family members and health professionals were involved in making the best interest decisions. The DoLS authorisations were reviewed regularly and this ensured that people's freedom was not being deprived unnecessarily. This showed that the provider was following the correct procedures if a person's liberty was restricted.

We saw a sign in the hallway which said, "[Name] if you want to go out ask a member of staff to open the door for you." Staff explained that previously this person would press the alarm bell thinking it would open the door, but this caused the fire alarm to sound which distressed other people who lived in the home. The member of staff went on to explain that since the sign was put in place, the person had not pressed the alarm and would ask a staff member to open the door. This showed that staff were keen not to restrict people's freedom and would find ways to support people.

Not all people who lived in the home were able to communicate verbally. We observed staff used a range of ways to communicate with people including using reference cards. The reference card had simple words and pictures of everyday items including bed, shower, "yes" and "no" which a person could point to, to communicate. Staff gave us an example of how they communicated with a person and said, "We can tell by their facial expression if they are in pain in which case we would ask a senior to provide them with pain relief medication." Another member of staff told us, "If people are unhappy I will know, they would be anxious, for example push me away or refuse things." Care files contained information about people's preferred method of communication and included commonly used signs or indicators for each individual. This gave new staff

members an understanding of how to communicate with each person and to understand what gestures or sounds meant.

Health records showed that people had access to health professionals as appropriate to their needs. A district nurse and a GP visited the home during our inspection which showed that people's health needs were regularly reviewed and guidance was sought from health professionals. These visits were routine visits which were to monitor the health of people who lived at the home and to provide routine nursing care. Records showed us that staff would request visit's for people who lived at the home if they had concerns, this meant that people received appropriate and timely care and they did not have to wait for a routine visit.

One person had recently been seen by the district nurse due to a sore on their hip. The district nurse had prescribed cream for the person. We checked the person's medication records which showed that the cream was being applied as prescribed. The risk assessment for the person said, "To make sure that I am sitting on my pressure relieving cushion." We saw the person in the lounge without any pressure relieving cushion underneath them. A member of staff approached the person and asked if they could place the cushion underneath them. The person gave consent to this and the cushion was placed underneath them. This showed that staff were aware of the how to act on the instructions given by health care professionals to ensure any health conditions were effectively treated.

Good

Is the service caring?

Our findings

We observed staff speaking kindly and respectfully to people and acting on their requests. However, we observed one interaction between a member of staff and a person who lived there which was abrupt. A care worker was assisting a person back to their room when another person stood up to leave the room. The care worker asked the person where they were going and the person responded that they were going to the toilet. The person clearly felt embarrassed that they had felt under pressure to announce it in front of other people. As the person left the room the care worker was heard to say "You're so rude!" We brought this to the attention of the registered manager who agreed to address this issue with the member of staff.

We saw that staff approached people appropriately, for example we observed one care worker sat down next to a person and got their attention before speaking to them. Another person was blind and staff were aware that they would become anxious if they was left alone. Staff spoke to this person regularly and reassured them of where they were and where other people were.

Staff demonstrated knowledge of people's life histories before moving to the home and used this information when speaking with them. Staff told us that one person used to be a bus driver and said, "They love their buses and trains, their pictures are really important to them and it helps us to sit and chat with [person]." Staff showed us a book on the table in front of this person which contained photographs of buses and trains. They explained, "[Person] can become a bit isolated at times so we use the book to chat with them." Throughout the day care workers picked up the book and looked at the pictures with the person who was observed to be smiling and pointing at the pictures.

Staff told us that it was important to them to maintain people's privacy and dignity when they were supporting them. One member of staff said, "I treat people how I'd like to be treated or how I would treat my own Mum or Dad." We observed staff knocked on people's doors before entering their rooms and one member of staff told us, "If I am helping [person] with their meal I always make sure that I discreetly wipe their mouth between mouthfuls, so others don't see." This showed that staff worked in a way that respected people's dignity.

Staff told us that they respected people's confidentiality by not discussing people's care in front of other people and keeping their records secure. We saw that care records were kept in lockable cupboards which were not accessible to members of the public or other people who lived in the home. We observed one incident where confidentiality was not respected. We asked a care worker about a person who lived in the home that appeared to be in pain. The care worker looked in the person's file and then shouted across the room where other people were sitting that the person had seen their GP that morning for a sore on their hip. This did not respect the person's confidentiality. We discussed this with the registered manager who assured us they would address this with the staff member involved.

Staff supported people to be as independent as they wanted to be. We saw in one person's care plan that it was documented that their mobility fluctuated. A staff member told us, "Some days [person] is able to stand up independently and transfer into their wheel chair, other days we need to use the hoist. It depends how

[person] is feeling." We observed that a care worker asked the person if they thought they could stand up. The person said that they "Would try". Two care workers then encouraged the person to stand and showed them where to position their hands on the armchair to push themselves up. The person was unable to stand and care workers explained they would need to get the hoist. The person said, "Okay" and the care workers said, "Let's try again tomorrow, you can do it!" This showed that staff were aware of this person's needs and supported them to maintain their mobility independently but also offered assistance if and when it was needed.

People and their relatives told us that they had been involved in decisions about people's care. Not all people living in the home had capacity to be involved in reviewing their care plans, and when this was the case we saw details of best interest decisions and capacity assessments. People who did have capacity had been asked about their preferences and what support they would like to receive. The care plans included details about what level of support people needed to maintain their independence. A person's care plan stated, "I can sometimes wash my own face; encourage me to do this by handing me a warm flannel." This showed that people were involved in deciding the level of care and support they needed.

Staff and relatives told us that people could visit at any time they wanted. Family members told us that they could visit their relatives in the communal areas or go their bedrooms. This helped people to maintain relationships that were important to them in settings that where they felt at ease.

Good

Is the service responsive?

Our findings

We asked people who lived at the home if they received care and support that reflected their preferences and needs. One person told us "I have no reason to complain, I'm happy here."

People received individualised care and support. In order to promote this, the registered manager told us that the staff team had received training from The Eden Alternative which is an organisation that promotes a philosophy of care for people who have dementia. We were told that staff worked to promote independence and were dedicated to bringing meaning and fulfilment to people who lived at the home in an aim to reduce boredom, loneliness and helplessness.

The registered manager told us that all staff aimed to encourage people to participate in activities that were meaningful to the individual. For example, after identifying that some people enjoyed the routine of cleaning which they had done before moving to the home, they had created a cleaning station where dusters were kept. We saw one person walk to the cleaning station, pick up a duster and dust areas of the corridor as they moved around the home.

A staff member told us that a post office had been created for a person who moved into the home and had previously worked at a post office. They told us, "[Person] enjoys sorting the envelopes and posting them, they look peaceful when they do this." This demonstrated how the staff responded to people's individual needs and encouraged them to participate in activities which gave them a sense of purpose.

People had access to a shop created in the home. A care worker told us this "Promotes people's independence as they can purchase small items for themselves like a bar of chocolate."

A small bar area was located downstairs. A care worker told us, "Some of the men like this as they can have a drink and play darts if they want to." This showed that people were encouraged to maintain activities that they would have done prior to moving to the home.

We saw a number of individual and group activities occurring throughout the day which included people listening to music, watching television, playing skittles and painting. We saw a member of staff encouraged a person to join in with the art activities. The care worker said to the person, "It's painting today in the lounge [Name], you really enjoyed it last week, do you want to try it again?" The care worker then held up a picture of a painting and showed it to the person. The person then nodded and smiled before being supported to join the activity.

We asked a person if they were offered choice about when they wanted to get up in the morning and when they went to bed. They responded, "Oh yes, they wouldn't have a problem with that at all if I wanted to stay in bed." Information in care plans documented peoples preferred daily routines for example. "I prefer to spend time in my bedroom but I will sometimes join in with communal activities." This showed that people were offered choice in how they spent their time and their daily activities.

We observed a staff 'hand over' of information about each person between one staff team and the next. Records of these meetings were kept and we saw they included information about people's changing care needs. One person was identified as requiring 15 minute checks because the sensor mat in their room was not working and they were at risk of falling. This fault had been reported to the repair company to be fixed. We discussed this with staff who confirmed that they carried out the checks. The person who lived in the home confirmed, "People come and check I'm okay regularly." We asked staff how they would update records if people's needs change and a member of staff told us, "I can make notes on people's care plans if things need changing and I tell the senior."

Each person who lived at the home had an individual care plan which detailed their health needs, likes and dislikes and personal histories including people that were important to them. Staff told us that they would read the person's care plan if they had not previously supported them so that they understood their individual needs.

Community links had been maintained by the registered manager, notably with a range of local churches. This meant the service maintained links with the local community, from which the majority of the people living there came.

A person who lived at the home told us, "I know the manager, if I had any complaints I could speak to them or one of the girls." Relatives told us they knew how to raise concerns and complaints.

Posters of information about how to raise complaints were on display in communal areas of the home in an easy read format. Information was also provided to people when they first came to live at the home. We reviewed the record of complaints held at the home and found they had been responded to in a timely way in line with the provider's complaints policy. Meetings with the registered manager were offered for people to discuss their complaint and response letters confirming actions taken following a complaint were sent.

No complaints had been made to the service in the 12 months prior to inspection. The registered manager analysed any complaints received and included information in the response which included what steps would be taken to improve standards in the home. These steps included training with staff and information to be given to all staff at team meetings.

Good

Is the service well-led?

Our findings

People we spoke with knew who the registered manager was and one person told us they thought they were, "Very nice – always around." A relative said that the provider's staff regularly contacted them and told them immediately if there was a change to their relative's health saying, "They're on the phone to us straight away."

The registered manager had an extensive knowledge of people who lived in the home and was actively involved in the day-to-day running of the service. They acknowledged that having oversight of all aspects of the service presented challenges and that they delegated aspects of their role, such as responsibilities for completing staff supervisions and completion of audits to other senior members of staff. Staff we spoke with had a good understanding of their roles and responsibilities.

All visitors we spoke with agreed the culture at the home was welcoming and positive. One visiting healthcare professional said, "It's very relaxed."
The provider's policies and procedures were clear and comprehensive. The policies included latest research so that best practice was delivered in the home.

A range of audits and checks took place to assess the quality and safety of service provided. This included checks on the premises to ensure it was safe. Checks on the quality of care people received also took place and we saw that actions were taken to address any shortfalls. For example, we saw that it had previously been identified that care plans were not always being reviewed monthly. In response to this the registered manager had addressed this issue during staff supervision sessions and improvements had been made.

Staff meetings took place regularly. Staff told us these helped to promote positive team working and that they felt supported in their job roles. They told us they could raise any concerns on an ad hoc basis, as well as at staff supervision and team meetings.

People and their relatives told us they had opportunities to put forward their suggestions about the running of the home. They told us that a meeting was planned for the week after our inspection which was "To help include us on the running of the unit." We were informed that these meetings were held every four to six weeks and people could raise any concerns or suggestions as well as plan for the future of the home.

Service satisfaction surveys were sent to people and their relatives. We reviewed the results of the most recent surveys and found they indicated high levels of satisfaction with the service. There was one area of improvement being suggested, namely activities. The manager had responded to this by arranging for the home to hire additional volunteers who were able to assist staff with domestic duties, such as making drinks for people. The manager told us that this allows care staff to spend more time with people and improving both the one to one and group activities provided.

The results of the surveys had been analysed and were displayed in a communal area. In the entrance area comments from relatives and thank you cards were displayed. This meant the registered manager involved

staff and people who used the service in considering how the service could continue to improve.

All incident reports, audits and training records were recorded on a computer system. This allowed the provider to assess the information and feedback any actions necessary during meetings with the registered manager. We were told that the provider would meet with the manager monthly and during this time staff training which needed reviewing would be highlighted as well as any trends of incidents. This showed that the provider was involved in assessing the quality and safety of the service provided.